Report on Survey and Reporting for the 2003 Medicare CAHPS® Disenrollment Reasons Survey

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INTRODUCTION

1.1 Overview of the Survey

This report describes the implementation and results of the 2003 Medicare CAHPS® Disenrollment Reasons Survey, hereafter referred to as the "Reasons Survey," which was conducted by the University of Wisconsin-Madison and RTI International for the Centers for Medicare and Medicaid Services (CMS). The Reasons Survey is designed to collect information on *reasons* why people with Medicare choose to leave their Medicare managed care plan and thus to help explain disenrollment rates. The survey results can help managed care organizations contracting with CMS understand and improve the experiences of their Medicare plan members.

The Reasons Survey provides information to three major constituents:

- CMS, to aid in fulfillment of its legislative mandate to present disenrollment rates to Medicare beneficiaries and to help CMS monitor the quality of the services for which it contracts;
- Medicare managed care plans, for use in quality improvement initiatives; and
- Medicare beneficiaries, to help them make more informed health plan choices.

Medicare beneficiaries can use the Medicare Personal Plan Finder—available on the CMS Medicare Web site, www.Medicare.gov—to make plan-to-plan comparisons on disenrollment rates and beneficiaries' reasons for leaving a plan. This same information is available through Medicare's toll-free help number (1-800-MEDICARE). The results from the 2003 Reasons Survey were posted on the Medicare Web site in early 2005.

The 2003 Reasons Survey was conducted from June 2003 through July 2004 with a sample of Medicare beneficiaries who disenrolled from a MA organization during each quarter of 2003. The major tasks completed during the 2003 Reasons Survey are described in this report. These include:

- Selecting a sample of Medicare beneficiaries who disenrolled from a MA organization in 2003 and surveying those beneficiaries to determine the reasons why those chose to leave their health plan;
- Processing and weighting survey data, and constructing data files needed for analysis;
- Analyzing data from each health plan to produce plan comparative information and submitting those results to CMS for posting on Medicare's Personal Plan Finder web site;

- Analyzing data from each health plan to produce plan comparative information for inclusion in individual health plan reports, and producing and distributing those reports to health plans; and

- Compiling plan comparative data for inclusion in individual reports to CMS Regional Offices, and producing and distributing those reports to the Regional Offices.

The project team was also responsible for analyzing data about various subgroups included in the survey and preparing and submitting to CMS a report describing analysis methods and results. These results are described in a separate forthcoming report entitled, "*Analysis of the 2003 Medicare CAHPS Disenrollment Reasons Survey*" (Mobley et al.).

1.2 Background and Need for the Project

The Reasons Survey is one of *two* surveys that form the Medicare CAHPS Disenrollment Survey sponsored by the CMS; the other is the Medicare CAHPS Disenrollment *Assessment* Survey (referred to as the "Assessment Survey").[1] Both surveys are being implemented as a result of legislative actions which require that 1) an annual CAHPS survey be conducted for all Medicare and Medicaid plans that have contracts with physicians or physician groups that are at high risk of referral to specialists and 2) CMS report two years' worth of disenrollment rates to Medicare beneficiaries. More background information on the two Medicare CAHPS Disenrollment Surveys is provided in the *Consumer Assessment of Health Plans Study (CAHPS) Medicare Disenrollee Field Test Analysis Report* (Guess et al., 2000), as well as in the *Survey Results and Reporting of the 2000 Medicare CAHPS Disenrollment Reasons Survey* report (Lynch et al., June 2003).

1.3 Overview of this Report

This report focuses on the implementation and results of the 2003 Reasons Survey. Information about the Reasons Survey conducted in prior years can be found in other reports, a list of which is provided in ***Section 5*** of this report. ***Section 2*** presents an overview of the 2003 Reasons Survey data collection and provides detailed information about the survey results. ***Section 3*** presents an overview of data processing and ***Section 4*** provides background on how these results were reported to both consumers (via the Medicare Web site) and to health plans. ***Appendix A*** contains a copy of the 2003 Reasons Survey Questionnaire. ***Appendix B*** provides a summary of the types of calls made to the project hotline and discusses key reasons sample members called. ***Appendix C*** provides the set of codes used for coding the most important and other reasons for leaving the health plan. ***Appendix D*** presents a summary of changes that were made to the 2004 Reasons Survey questionnaire.

It should be noted that the terms "health plan," "plan" and "sample plan" are used throughout this report to refer to individual contracts that CMS holds with managed care organizations, both corporate and non-profit. However, according to CMS regulations, a "plan" is a benefits package, and each contract can offer any number of different plan benefit packages.

[1] The UW-M and RTI project team conducted the annual implementations of the Assessment Survey in 2000, 2001, and 2002; however, the survey is currently being conducted for CMS by another contractor.

Readers of this report should keep in mind that these terms in this report refer to individual contracts that CMS holds with Medicare managed care organizations rather than to a benefits package.

SECTION 2
DATA COLLECTION

2.1 Overview

Although data were analyzed on an annual basis, the 2003 Reasons Survey was conducted on a quarterly basis to determine the *reasons* Medicare beneficiaries leave their Medicare managed care plans. A sample of Medicare beneficiaries who disenroll during one quarter was selected at the end of the quarter, with data collection for that quarter taking place during the next quarter. The target population for the 2003 Reasons Survey consisted of Medicare beneficiaries who *voluntarily* left a Medicare Advantage plan during calendar year 2003. The Reasons Survey was administered as a mail survey with telephone follow-up of nonrespondents. Data collection for the survey took place from June 2003 through July 2004. ***Exhibit 2-1*** presents the sampling window and data collection schedule for the 2003 Reasons Survey.

Exhibit 2-1
2003 Reasons Survey Sampling Window/Data Collection Schedule

Reasons Quarter	Sampling Window (During which Beneficiaries Disenrolled)	Data Collection Period
1	January–March 2003	June–October 2003
2	April–June 2003	September 2003–January 2004
3	July–September 2003	December 2003–June 2004
4	October–December 2003	March–July 2004

2.2 Sample Design and Selection

The sampling frame for the 2003 Reasons Survey consisted of all Medicare beneficiaries who had voluntarily disenrolled from one of 168 M+C organizations and continuing cost contracts in 2003. To be included in the sample, health plans were required to have contracts in effect on January 1, 2002; that is, they must have been in operation for at least one full year prior to the beginning of the survey year.

The overall sampling goal for the Reasons Survey was to select up to 388 sample members per plan across all four quarters. However, sampling across quarters is not uniform. It is usually based on the disenrollment pattern of the previous year. In 2002, lock-in was scheduled to be implemented. Since it was an atypical year, we chose to use 2001's disenrollment pattern instead. Thus, we selected 20.6% of our sample in Quarter 1, 19.1% in Quarter 2, 20.1% in Quarter 3, and 40.2% in Quarter 4.

We also adjusted our sampling rate among the three largest plans that had high numbers of disenrollees. Since a fixed number of disenrollees is drawn from each plan, these three plans had the largest weights. When the data is aggregated for national-level analyses, they contribute greatly to the unequal weighting effect (UWE) and lower the overall effective sample size. We used optimal allocation and determined that selecting an additional 1,000 sample members from these plans (total, not 1,000 from each) would dramatically lower the UWE. This has proven to be a very effective way to enhance the power in our study with minimal costs.

Exhibit 2-2 displays the samples sizes for the last three years by quarter. From 2001 to 2002 the sample size dropped significantly primarily due to the fact that there were fewer M+C organizations under contract. From 2002 to 2003 the sample size markedly increased (although not to 2001 levels). This is primarily due to three reasons. First, the Sterling organization was in the study for the entire 2003 survey. It had originally entered the study in the last half of 2002. Since sampling for Sterling disenrollees was conducted using eight strata, this was the equivalent of eight plans worth of sample. Second, as noted above, we added 1,000 cases from the optimal allocation. And last of all, we started using the GHP file that was released two months after a quarter had ended. Originally we had been using the file that was available immediately after the quarter had ended, but we began noticing that it was starting to miss a significant percentage of disenrollees in the prior month. So by using a more accurate file, we became more efficient in selecting our samples for small and medium-sized plans.

Exhibit 2-2
Reasons Survey Sample Size by Quarter

2003 Reasons Survey		2002 Reasons Survey		2001 Reasons Survey	
Quarter	**Sample Size**	**Quarter**	**Sample Size**	**Quarter**	**Sample Size**
1	12,462	1	11,716	1	13,595
2	11,425	2	10,501	2	12,454
3	11,661	3	12,118	3	15,017
4	23,524	4	18,906	4	23,364
Total	**59,072**	**Total**	**53,241**	**Total**	**64,430**

2.3 Survey Instrument

We collected data in the 2003 Reasons Survey via a mail survey with telephone follow-up of nonrespondents. The Reasons Survey was designed to collect information about the reasons *why* sample members left their former Medicare managed health care plan. The questionnaire used in the 2003 survey contained 80 questions, three more than were included in the 2002 survey questionnaire. The 2003 survey included:

- Four screening questions to verify that the respondents were voluntary disenrollees;

- Thirty-seven questions about reasons for leaving the health plan, including 33 preprinted reasons, one question about any other reasons for leaving, and one question that asked for *the most important reason* for leaving the plan;

- Seven questions asking the respondent to rate the sample health plan, about the care received from that plan and the experience with that plan;

- Ten questions about the appeals process; and

- Twenty-two questions about health status and demographic characteristics.

The screening questions were designed to identify sample members who were considered "involuntary" disenrollees and to exclude them from the survey. Reasons for ineligibility to participate in the 2003 Reasons Survey included:

- The sample member never left the Medicare managed care health plan for any length of time during the year 2003;

- The sample member moved out of the area where the Medicare managed care health plan was available;

- The Medicare managed care health plan stopped serving Medicare beneficiaries in the sample member's area;

- The sample member was enrolled in the plan without his or her knowledge (for example, by a salesperson or family member); or

- The sample member was accidentally disenrolled from the plan (for example, due to a paperwork or clerical error).

In addition, deceased and institutionalized sample members were ineligible to be included in the Reasons Survey.

The telephone survey instrument was designed to mirror the mail survey instrument as closely as possible and was developed as a computer-assisted telephone interview (CATI). Both the mail and telephone survey instruments were customized so that they were plan-specific for each respondent. The survey instruments were also translated into Spanish and were available upon request, as either a hard copy questionnaire or as a Spanish-language telephone interview.

The Reasons Survey questionnaire was revised slightly in the summer of 2003 after the 2002 Reasons Survey was conducted as a result of cognitive testing activities conducted by the Medicare CAHPS Disenrollment project team to better ask the questions of disenrollees from PFFS plans and cognitive testing activities conducted jointly by the CAHPS Enrollee and CAHPS Disenrollment teams to support revisions to the series of "appeals" questions. As a result of the testing activities, we created two versions of the questionnaire—one version to be used with disenrollees from PFFS plans and the other to be used with disenrollees from all Medicare

Advantage plans. More detail about the changes made at the end of the 2002 Reasons Survey implementation can be found in the report for that survey year (Lynch et al., November 2004).

A copy of the questionnaire used in Quarters 2-4 is included in ***Appendix A***.

2.4 Data Collection Activities

We conducted data collection and data processing activities for Quarters 1-4 of the 2003 Reasons Survey from June 12, 2003, through July 12, 2004. For each quarterly implementation of the survey, we used the same multi-wave survey process, which involved numerous attempts to reach respondents in English and/or Spanish by regular mail, telephone, and overnight mail. The schedules for the mail and telephone collection activities on the 2003 Reasons Survey are shown in ***Exhibits 2-3*** and ***2-4***, respectively.

Exhibit 2-3
2003 Reasons Survey Data Collection Schedule: Mail Survey

	Mailing Week			
Activity	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Pre-notification lead letter	6/12/03	9/4/03	12/5/03	3/8/04
Toll-free project hotline open for in-bound requests for telephone interviews	6/12/03	9/4/03	12/5/03	3/8/04
Initial questionnaire package	6/16/03	9/8/03	12/12/03	3/15/04
Thank you/reminder letter/postcard	7/7/03	9/25/03	12/30/03	4/19/04
Second questionnaire package to nonrespondents	7/25/03	10/16/03	1/21/04	5/7/04
Third questionnaire package to nonrespondents	9/22/03	12/1/03	5/4/04	6/15/04

Exhibit 2-4
Telephone Follow-up Data Collection Schedule for 2003 Reasons Survey, by Quarter

Quarter	**Telephone Interviewers Trained**	**Telephone Follow-up**
1	9/5/03-9/6/03	9/7/03-10/26/03
2	11/14/03-11/15/03	11/16/03-1/11/04
3	4/14/04	4/16/04-6/2/04
4	6/2/04-6/3/04	6/3/04-7/11/04

Sample members had the option to call a toll-free project hotline at any time during the data collection period in each quarter if they had questions, wanted to refuse, or wanted to request a telephone interview. Telephone interviewers were trained just prior to the beginning of the mail survey so that they could conduct interviews with sample members who called to request a telephone interview. In addition, sample members had the option to speak with a Spanish-speaking hotline representative or request a telephone interview in Spanish with a bilingual telephone interviewer. Project data collection staff received telephone calls precipitated by receipt of the mailings from approximately 9.3 percent of the total sample for the 2003 Reasons Survey. A summary of the 2003 Reasons Survey hotline experience is provided in ***Appendix B***.

Because CMS does not have access to telephone numbers for Medicare beneficiaries, it was necessary to conduct some preliminary tracing prior to beginning the telephone follow-up portion of the data collection. We used a combination of four sources to obtain a current telephone number for the sample members, including the following:

- Requested telephone numbers from each of the Medicare managed care health plans represented in the sample (in Quarter 4, we did not request telephone numbers from health plans that were not renewing their M+C contract with CMS in 2004);
- Obtained telephone numbers from a commercial telephone number matching service;
- Requested telephone numbers from the Social Security Administration (SSA) through an arrangement between the CMS and the SSA; and
- Conducted limited intensive tracing activities performed by RTI's specialized in-house Tracing Operations Unit (TOPS).

More detailed information about the survey data collection methods is provided in the *Survey and Reporting for the 2000 Medicare CAHPS Disenrollment Reasons Survey Report*.

2.5 Quality Control Procedures

To ensure that data of the highest possible quality would be collected, RTI project data collection staff implemented quality control procedures during every phase of the mail and telephone survey data collection process. These were discussed in detail in the 2000 Reasons Survey final report and are listed briefly below.

- Prior to sending the prenotification letter, we sent sample member addresses to an outside address service firm to append 4-digit zip codes to the existing zip code information.
- We printed a unique RTI identification number on every page of the questionnaire, ensuring that if pages became separated during the scanning procedure, all data associated with a particular respondent would remain with that respondent's ID.

- During each mailing, every 10th package was checked to verify that it contained the correct materials and that it was assembled correctly.

- Quality control checks on the work performed by the Data Receipt staff were conducted by checking an "error log" in the project control system and by maintaining and checking a "problem bin" for ineligible surveys and surveys containing hand-written notes. Project data collection staff reviewed these cases on a regular basis and assigned the appropriate status code to each case.

- We thoroughly trained all telephone interviewers on telephone follow up procedures with mail survey nonrespondents before telephone data collection began, and required all interviewers to complete and pass a written "exit" exam after the training session ended. Telephone interviewers were not allowed to begin work on this project unless they had performed satisfactorily during the training and passed the exit exam.

- Telephone supervisors and project data collection staff used RTI's computerized silent monitoring system to unobtrusively listen to and evaluate a sample of calls made by all telephone interviewers. These staff provided feedback to interviewers about their performance after the calls were monitored and, if necessary, reviewed relevant data collection procedures with them.

In addition to the measures described above, project staff held quality circle meetings with telephone interviewers throughout the data collection period. The purpose of these meetings was to discuss the status of telephone survey data collection, identify questionnaire items that were problematic for respondents, and to discuss reasons that some sample members initially gave for not wanting to participate in the survey and possible ways to overcome those objections to participation.

2.6 Data Collection Results

Data collection efforts on the 2003 Reasons Survey resulted in an overall response rate of 65.4 percent. This response rate was calculated using the following formula:

$$\frac{\textbf{Numerator} = \text{The number of completed interviews}}{\textbf{Denominator} = \text{All sample members included in the sample } \textit{minus} \text{ those considered ineligible (i.e., institutionalized, deceased, or involuntary disenrollees)}}$$

The response rate obtained in each quarter and overall for the 2001 through 2003 Reasons Surveys are shown in ***Exhibit 2-5***.

Note that the response rate in the 2003 survey declined slightly from 2002. As can be seen in ***Exhibit 2-5***, the response rate in the 2003 Reasons Survey varied by quarter. The response rates for Quarters 1 and 2 (66.5% and 67.4%) were comparable to those in previous years but the response rate for Quarter 3 (61.5%) was the lowest we had seen in any quarter over the past 3 years of data collection. In addition, the reponse rate for Quarter 4 (65.6%) which has the largest sample size was also lower than it had been in previous fourth quarters. Since the

Exhibit 2-5
Sample Distribution and Response Rate by Quarter: 2001 through 2003 Reasons Surveys

	Quarter	Number Selected	Completed Interviews	Response Rate
2003	1	12,462	6,106	66.5%
	2	11,425	5,354	67.4%
	3	11,661	4,660	61.5%
	4	23,524	11,345	65.6%
	Subtotal	**59,072**	**27,465**	**65.4%**
2002	1	11,716	5,927	67.4%
	2	10,501	5,119	67.0%
	3	12,118	5,119	64.4%
	4	18,906	9,589	66.4%
	Subtotal	**53,241**	**25,754**	**66.3%**
2001	1	13,595	6,965	69.5%
	2	12,454	5,587	64.6%
	3	15,017	6,362	65.4%
	4	23,364	11,923	69.9%
	Subtotal	**64,430**	**30,837**	**67.8%**

data collection modes and procedures are the same in all quarters and in all survey years, it is difficult to surmise what factors could have led to lower response rates for the second half of 2003 and thus the slight decline across the survey years.

The final disposition status of sample members selected into the 2001 through 2003 Reasons Surveys is shown in ***Exhibit 2-6***. Almost 29 percent of the 2003 sample was ineligible to participate in the survey – that is, the sample members had died or became institutionalized after the sample was selected, or they were considered involuntary disenrollees. Involuntary disenrollees include sample members who reported that:

- the plan stopped serving the area;
- they moved out of the plan's service area;
- they were enrolled in the plan without their knowledge;
- they were accidentally disenrolled from the plan due to a paperwork or clerical error;
- they did not disenroll from the sample plan; or
- they were not on Medicare.

The "Other Ineligible" category shown in ***Exhibit 2-6*** includes sample members who marked "yes" to two or more of the questions designed to identify involuntary disenrollees, or

Exhibit 2-6
Final Disposition of the 2001 through 2003 Reasons Survey Samples

Sample Disposition	2003 Reasons Survey		2002 Reasons Survey		2001 Reasons Survey	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Completed Interviews	**27,465**	**46.5%**	**25,754**	**48.4%**	**30,837**	**47.9 %**
Mail Survey	21,968	37.2%	21,574	40.5%	25,625	39.8%
Telephone Interview	5,497	9.3%	4,180	7.9%	5,212	8.1%
Eligible Non-Respondents	**14,555**	**24.6%**	**13,066**	**24.5%**	**14,612**	**22.7%**
Mentally/Physically incapable	882	1.5%	659	1.2%	777	1.2%
Language Barrier	347	0.6%	391	0.7%	339	0.5%
Refusal	4,281	7.2%	3,955	7.4%	4,381	6.8%
Unable to contact after repeated attempts	3,908	6.6%	3,817	7.2%	3,189	4.9%
Promised to return mail survey	67	0.1%	143	0.3%	74	0.1%
Unable to obtain phone number	5,070	8.6%	4,101	7.7%	5,852	9.1%
Ineligibles	**17,052**	**28.9%**	**14,421**	**27.1%**	**18,981**	**29.5%**
Deceased	1,768	3.0%	1,385	2.6%	1,579	2.5%
Institutionalized	2,126	3.6%	1,811	3.4%	1,322	2.1%
Did Not Leave Sample Plan	2,694	4.6%	1,859	3.5%	1,898	2.9%
Plan No Longer Offered	1,035	1.8%	1,556	2.9%	6,116	9.5%
Moved Outside Plan Service Area	8,047	13.6%	6,668	12.5%	5,956	9.2%
Paperwork Error	372	0.6%	422	0.8%	793	1.2%
Enrolled by Other	207	0.4%	158	0.3%	448	0.7%
Other Ineligibles[2]	803	1.4%	562	1.1%	869	1.3%
Eligible Sample Members	**42,020**	**71.1%**	**38,820**	**72.9%**	**45,449**	**70.5%**
Original Sample	**59,072**	**100%**	**53,241**	**100%**	**64,430**	**100%**

[2] Includes respondents who reported not being on Medicare, never being enrolled in the sample plan, or who gave inconsistent answers to the screening questions.

who reported that they were never enrolled in the sample plan. Approximately 7.2 percent of the 2003 sample refused to participate in the survey, fairly constant with prior years. We were unable to contact 6.6 percent of mail survey non-respondents after repeated attempts, and 0.1 percent promised to complete and return the mail questionnaire when they were contacted by telephone but did not. Another 1.5 percent was physically or mentally incapable of participating in the interview, and 0.6 percent did not speak English or Spanish (language barriers). We were unable to obtain a telephone number for 8.6 percent of the mail survey non-respondents**.**

The percentage of the sample that was deemed ineligible climbed slightly from 2002 to 2003 (from 27.1% to 28.9%). This continues to be a difficult hurdle to obtaining higher response rates, as it is not possible through our sampling frame to identify involuntary disenrollees a priori. Thus, we classify almost a third of the sample as ineligible each quarter, even if they return completed questionnaires, if their most important or "other" reason makes them an involuntary disenrollee. Similarly, we must consider all nonrespondents to be eligible, when the likelihood is that about the same proportion of nonrespondents are involuntary disenrollees and should be declared ineligible. Four categories of ineligibles showed an increase from prior years: deceased, institutionalized, those reporting that they did not leave the sample plan, and those reporting that they left because they moved. From 2001 to 2003, the percentage of disenrollees indicating that they left because they moved increased over 4 percentage points from 9.2% to 13.6%. Beginning with the 2004 survey, we changed our method of identifying "movers" to take into account moves over a longer period of time, with the hope that we will be able to remove a greater percentage of movers from the frame before selecting the sample. The percentage of individuals for whom we were unable to obtain a telephone number increased slightly from 2002 (7.7%) to 2003 (8.6%), however this still reflects a decrease from earlier survey years when we were not obtaining telephone numbers through the Social Security Administration.

Exhibit 2-7 shows the percentage of cases that returned a completed questionnaire after each main event or stage of data collection (first, second, and third mailings and telephone follow-up) for the 2001, 2002, and 2003 Reasons Surveys.

2.7 Non-Response Analysis and Weighting

We conducted a non-response analysis on the 2003 Reasons Survey data after the data were cleaned. For this analysis, we classified sample members as respondents or non-respondents; response propensities were then modeled using logistic regression in SUDAAN®. The predicted response propensities were used to adjust the initial design-based weights upward for respondents so that they represented both respondents and non-respondents; weights for non-respondents were set to zero. The general approach used to adjust weights for non-response is described by Folsom (1991) or Iannacchione, Milne, and Folsom (1991).

For purposes of non-response adjustments, sample members who provided information on eligibility status were treated as respondents. Subsequently, those who were ineligible (deceased, institutionalized, involuntary disenrollees) were also given a weight as if they had completed the survey. Since we do not know the eligibility status of non-respondents, this approach allowed us to estimate the proportion of ineligible sample members among the non-respondents based on the respondent sample. When the ineligibles are discarded with their

Exhibit 2-7
Response Per Survey Stage, 2001 through 2003 Reasons Surveys

Response Per Survey Stage	2003 Reasons Survey			2002 Reasons Survey			2001 Reasons Survey		
	No. Sample Members	No. Completed Question-naires	Percent of Total Sample	No. Sample Members	No. Completed Question-naires	Percent of Total Sample	No. Sample Members	No. Completed Question-naires	Percent of Total Sample
First Mailing	59,072	18,150	30.7%	53,241	16,348	30.7%	64,430	19,007	29.5%
Second Mailing	35,746	3,525	6.0%	30,860	4,946	9.3%	37,989	6,207	9.6%
Spanish Mail Survey	165	144[3]	0.1%	123	41	0.1%	96	29	0.0%
Telephone Follow-Up	28,486	5,497	9.3%	22,188	4,180	7.9%	26,595	5,212	8.1%
Third (Overnight) Mailing	2,539	149	0.3%	1,533	239	0.4%	5,162	382	0.6%
Total Number of Respondents		**27,465**	**46.5%**		**25,754**	**48.4%**		**30,837**	**47.9%**
Eligible Sample Members		**42,020**	**71.1%**		**38,820**	**72.9%**		**45,449**	**70.5%**
Final Response Rate[4]			**65.4%**			**66.3%**			**67.8%**

[3] 47 of the 144 cases reflect questionnaires returned in response to requests for Spanish questionnaires. The remaining 97 Spanish questionnaires were returned from sample members who disenrolled from a health plan located in Puerto Rico. All sample members selected from that plan receive questionnaire materials in Spanish unless otherwise requested.

[4] The final response rate was calculated as the eligible respondents divided by eligible sample members. The response rate includes all beneficiaries who returned a completed questionnaire, including some questionnaires that were later deemed incomplete for analytic purposes.

weighted values, the sum of the remaining weights (only including eligible sample members that completed a survey) represents the *estimated population of eligible disenrollees*.

We simultaneously added to the model—the design variables, demographics, rapid disenrollment, dual eligibility, MC/FFS destination, address variables, and OMB census-defined variables such as regions, divisions, and metro-/micropolitan indicators. They were then removed in a backwards-stepwise fashion; however, the design variables were always retained regardless of significance. We explored meaningful two-way interaction and kept variables with p-values of 0.20 or less.

The final non-response, logistic regression model contained the independent variables:

- Age,
- Race,
- Rapid disenrollment,
- Dual eligibility,
- Apartment addresses,
- Addresses with gatekeepers,
- OMB micropolitan statistical areas,
- OMB metropolitan statistical areas, and
- OMB metropolitan divisions.

Although this model has more variables in previous years, the overall results were similar. Sample members that are under age 65 or over age 80 are less likely to respond to the survey. Non-whites are less likely to respond than whites. Beneficiaries that disenroll within six months of signing up with their managed care plan (i.e. rapids) have lower response propensities than those with longer enrollment periods. And the dually eligible tend to have the lowest response propensity of all the socio-demographic variables.

Addresses at apartments tended to be less likely to respond to the survey. However, addresses with a gatekeeper tended to have a higher odds of response. A gatekeeper is broadly defined as someone other than the sampled beneficiary that receives their mail. “John Doe in care of Jane Doe” or “Helen Smith for Harry Smith” are common examples in the data.

Three of the OMB census variables were also significant. A *micropolitan statistical area* (2000 OMB definition) has an urbanized area with between 10,000 and 50,000 people living in it. A *metropolitan statistical area* has at least one urbanized area with 50,000+ people in it. When a metropolitan statistical area has a core that exceeds 2.5 million people, OMB subdivides it into smaller areas called *metropolitan divisions*. However, these definitions are more complex than looking at the population size within a county. They also take into account the economic and social integration with neighboring counties.

Micropolitan and metropolitan statistical areas had a significantly higher response propensities than rural areas. However, when the population density reached the stage of a metropolitan division (over 2.5 million people in the general area), the response propensity declined significantly. With these variables in the model, the geographic regions of the United States were no longer a significant predictor.

Exhibit 2-8 displays the response rates by demographic & geographic categories as well other beneficiary characteristics. This table contains all of the plans in the 2003 Reasons Survey except Sterling Health Insurance. Since Sterling Health Insurance is a private fee-for-service (PFFS)plan, we have developed separate response rate tables in ***Exhibits 2-9*** and ***2-10***. Sterling's disenrollee population is slightly different than the average Medicare health plan. They have almost twice as many disenrollees that are under-65 compared to other plans (19.6% vs 10.5%). Also, they have less than half the proportion of minorities as other plans (8.3% vs 20.1%). Note that these demographic statistics are only for the disenrollee population and not reflective of the entire plan. And these are the population numbers from our stratified random sample; however they are very close to the actual frame counts.

With regards to response rates, Sterling was above the norm. Overall their response rate was 74.2% (compared to 64.9%). They were also higher in every single demographic category. Even in categories that are historically low, they seemed to respond at a higher rate, e.g., compare the dually eligible in which Sterling had a 78.3% response rate vs 56.7% for the average health plans.

Finally, two sets of weights were constructed for the Reasons Survey. The first weight, referred to as the disenrollment weight, represents all eligible disenrollees in each plan and was developed as discussed above. The second weight is simply scaled by a plan-level multiplicative constant so that the weights sum to the proportion that voluntary disenrollees represent of the total population of enrollees. These latter weights (referred to as Enrollment weights) were used for weighting results for public reporting that are based on all members in a plan rather than just disenrollees.

2.8 Evaluation and Areas of Improvement for the 2004 Survey

We examined patterns in the responses to the 2003 Reasons Survey questionnaire as part of our ongoing efforts to monitor and evaluate the data collection process and survey questionnaire. We also worked jointly with the two other CAHPS teams to ensure that, where applicable, the order and wording of the questions in the Reasons Survey was identical to those used in the other surveys. During the 2003 survey implementation period, we also conducted cognitive testing and quantitative analyses of the most important reason item to better understand how respondents answer the item and whether the current coding scheme leads to any bias in reporting results. Our findings from this activity were submitted to CMS in March 2004 (Lynch et al., March 2004).

As a result of the cognitive testing activity, we made some minor changes to the formatting and placement of the two open-ended text questions in the survey, which went into effect for the 2004 survey implementation year. We also worked jointly with the Enrollee Survey team to revise the Appeals and Complaints series of questions, replacing them with a new set, again beginning with the 2004 survey implementation. A summary of these changes is presented in ***Appendix D***.

Exhibit 2-8
2003 Reasons Survey Response Rates by Demographic Characteristics[5]

Subpopulation		Total Sample		Respondent Sample		Response Rates Among Eligibles[6]
Overall	USA	56,396	100.0%	25,964	100.0%	64.9%
Gender (EDB)	Male	23,201	41.1%	11,111	42.1%	66.1%
	Female	33,195	58.9%	14,853	57.9%	64.1%
Age Group (EDB)	<65	5,907	10.5%	2,875	11.2%	64.2%
	65-69	13,247	23.5%	6,852	25.0%	68.5%
	70-74	13,355	23.6%	6,700	24.8%	67.6%
	75-79	10,595	18.8%	4,885	18.8%	64.8%
	≥80	13,292	23.6%	4,652	20.2%	57.6%
Race (EDB)	White	45,074	79.9%	21,160	78.1%	67.7%
	Black	7,337	13.0%	3,262	14.1%	58.0%
	Other/Unknown	3,985	7.1%	1,542	7.8%	49.4%
Dual Eligible (EDB)	Yes	10,809	19.2%	4,289	18.9%	56.7%
	No	45,587	80.8%	21,675	81.1%	66.8%
Rapid (EDB)	Yes	8,763	15.5%	4,011	16.6%	60.3%
	No	47,633	84.5%	21,953	83.4%	65.9%
Census Region	I. New England	2,965	5.2%	1,291	5.0%	63.9%
	II. Middle Atlantic	12,477	22.1%	5,832	23.3%	62.6%
	III. East North Central	7,518	13.3%	3,484	12.9%	67.5%
	IV. West North Central	4,049	7.2%	1,982	7.0%	71.1%
	V. South Atlantic	7,640	13.6%	3,172	13.7%	58.0%
	VI. East South Central	2,512	4.5%	1,319	4.7%	70.2%
	VII. West South Central	3,532	6.3%	1,754	6.5%	66.9%
	VIII. Mountain	5,828	10.3%	2,708	9.9%	68.6%
	IX. Pacific	9,358	16.6%	4,197	16.0%	65.5%
	Other	517	0.9%	225	1.0%	58.3%

[5] All plans except for Sterling (H5006) which is in separate tables.

[6] 16,400 samples members were ineligible (29.0%).

Exhibit 2-9
2003 Reasons Survey Response Rates by Demographic Characteristics for Sterling

Subpopulation		Total Sample		Respondent Sample		Response Rates Among Eligibles[7]
Overall	USA	2,676	100.0%	1,501	100.0%	74.2%
Gender (EDB)	Male	1,123	42.0%	610	41.2%	73.1%
	Female	1,553	58.0%	891	58.8%	74.9%
Age Group (EDB)	<65	526	19.6%	316	19.9%	78.4%
	65-69	557	20.8%	336	21.6%	76.7%
	70-74	573	21.4%	327	22.1%	73.3%
	75-79	505	18.9%	285	19.0%	74.0%
	≥80	515	19.3%	237	17.4%	67.3%
Race (EDB)	White	2,453	91.7%	1,381	90.8%	75.2%
	Black	140	5.2%	77	6.1%	62.6%
	Other/Unknown	83	3.1%	43	3.1%	67.2%
Dual Eligible (EDB)	Yes	323	12.1%	198	12.5%	78.3%
	No	2,353	87.9%	1,303	87.5%	73.6%
Rapid (EDB)	Yes	563	21.0%	269	19.6%	67.8%
	No	2,113	79.0%	1,232	80.4%	75.7%
Census Region	I. New England	1	<0.1%	1	<0.1%	100.0%
	II. Middle Atlantic	238	8.9%	153	9.8%	76.9%
	III. East North Central	337	12.6%	180	11.9%	74.7%
	IV. West North Central	20	0.8%	12	0.7%	80.0%
	V. South Atlantic	53	2.0%	24	1.8%	64.9%
	VI. East South Central	354	13.2%	263	15.8%	82.5%
	VII. West South Central	1,136	42.4%	629	43.1%	72.1%
	VIII. Mountain	133	5.0%	61	4.4%	69.3%
	IX. Pacific	404	15.1%	178	12.5%	70.6%
	Other	0	0%	0	0%	n/a

[7] 652 sample members were ineligible (24.4%).

Exhibit 2-10
2003 Reasons Survey Response Rates by Sampling Strata for Sterling

Subpopulation		Total Sample		Respondent Sample		Response Rates Among Eligibles[8]
Overall	USA	2,676	100.0%	1,501	100.0%	74.2%
Strata	I. Texas	388	14.5%	204	13.9%	72.6%
	II. Louisiana	385	14.4%	221	15.6%	70.2%
	III. Washington	344	12.8%	164	11.3%	71.6%
	IV. Oklahoma	333	12.4%	187	12.4%	74.2%
	V. Tennessee	336	12.6%	252	15.1%	82.4%
	VI. Ohio	272	10.2%	148	9.4%	77.5%
	VII. Pennsylvania	230	8.6%	149	9.6%	76.8%
	VIII. Remainder of USA	388	14.5%	176	12.7%	68.8%

[8] 652 sample members were ineligible (24.4%).

SECTION 3
DATA PROCESSING

3.1 Overview

Data processing on the 2003 Reasons Survey involved receiving incoming mail from the mail survey and updating the computerized control system to reflect the status of incoming mail, scanning data from completed questionnaires, and assigning codes to open-ended text entries, including other and the most important reason (MIR) for leaving the plan. These processes are described in this chapter.

3.2 Data Receipt and Scanning

Data Receipt staff updated a computerized control system as mail was received to indicate the status of incoming mail. They entered a disposition/status code of "999" in the computerized control system for all non-blank questionnaires. All questionnaires assigned the 999 code were then scanned, and a computer algorithm determined the final event status code. Project staff also updated cases in the control system as they received telephone calls from sample members or their families that resulted in a final disposition of a case (such as a sample member being deceased or incapable of participating in the interview). The control system was also updated with new addresses as new address information was obtained (either from returned mail or reported by telephone calls from sample members.)

Ineligible sample members, those who left the plan for a reason that made them an involuntary disenrollee and those who were institutionalized or deceased, were identified from responses to the questionnaire, via a telephone interview, via a note submitted with a questionnaire, or via a call to the project hotline. In addition, project staff coded cases as ineligible based on a review of open-ended text entries for the "most important" or "other" reason.

3.3 Coding Open-Ended Text Entries

The 2003 Reasons Survey contained several questions with an open-ended response choice, including questions that asked if there were any other reasons for leaving the plan not already addressed in the questionnaire and the most important reason (MIR) for leaving the plan. Project staff assigned a numeric code to the other reasons for leaving (if any) and to the MIR using a list of 68 codes originally developed by the analysis team during the 2000 Reasons Survey and expanded during the 2001 survey (based on reasons reported during the 2000 Reasons Survey). Although we did not add any new codes during the 2002 Reasons Survey, we did add one new code for the 2003 survey:

302 Former plan reduced or changed benefits or coverage

A complete list of all codes used in the 2003 survey is included in ***Appendix C***. More detailed information about the development of the reasons for leaving codes, training of coders,

and quality control checks on coded data can be found in the final report for the 2000 Reasons Survey (Lynch et al., July 2003).

Any sample member whose most important reason for leaving the plan was a reason that made him/her an involuntary disenrollee was assigned an ineligible code. Project staff also coded any open-ended text entries recorded in the questions about who completed the questionnaire. Any cases assigned the code that represented any of the following reasons were deemed ineligible for the survey, and questionnaire data for these cases were removed from the data file:

- Sample member institutionalized;
- Sample member deceased;
- The plan stopped serving the area;
- Sample member was accidentally disenrolled (for example, by a paperwork or clerical error);
- Sample member was enrolled without his/her knowledge (for example, by a friend, relative or salesperson);
- Sample member moved out of the plan's service area;
- Sample member did not disenroll from the sample plan; or
- Sample member was not on Medicare or the specific health plan being asked about.

3.4 Questionnaire Completeness Criteria

Cases were retained in the 2003 Reasons Survey analysis file if the respondent answered "yes" to at least one of the preprinted reasons for leaving questions (Questions 5-38) *or* gave some other reason for leaving in Q40 *or* gave a most important reason for leaving in Q41. However, even if a case met these completeness criteria, it was excluded from the data file (and treated as ineligible) if the respondent's most important or "other" reason for leaving the plan was one that made him/her an involuntary disenrollee.

3.5 Data File Construction

This section describes procedures used to construct files that were used for subgroup analysis and health plan and consumer reporting.

Recoding Data—After the raw data file was cleaned and all cases identified as ineligible for inclusion in the survey were removed from the file, we created a master data file that consisted of all cases that had marked at least one reason for leaving the plan. The responses for the remaining respondents were recoded such that all "don't know" responses and refusal codes (i.e., where a respondent refused to answer a specific question) provided in telephone interviews were coded as blank.

Flagging Cases and Adding Other Variables to the Data File—We flagged cases on the master data file that were to be excluded from public reporting and health plan reporting according to specific criteria. The following cases were flagged so that they would not be included in consumer/public and health plan reporting:

- Cases in non-renewing plans (including plans not renewing their M+C contract in 2004 or 2005);
- Cases in plans that were bought by a new owner;
- Cases indicating that their most important reason for leaving was because their employer no longer offered the plan or they left to join TRICARE for Life, the military health insurance program;
- All cases in plans with fewer than 100 completed interviews (i.e., the suppression threshold) or with less than 1,000 cumulative enrollment in 2003.[9]

In addition to flags to indicate cases that would not be included in consumer and health plan reporting, we also added a flag to identify cases of plans that consolidated or merged with another plan, so that data from these plans would be reported under the surviving plan (rather than the subsumed plan).

In constructing the master data file, we added variables to the data file that would be needed in consumer and health plan reporting as well as for subgroup analysis. These variables included two sets of weights: (1) design-based weights (disenrollment weights); and (2) weights that represent the proportion of disenrollees with respect to enrollees within a plan (enrollment weights), demographic variables from CMS' Enrollment Data Base (EDB) (such as gender, race, and age), and variables to indicate whether the interview was conducted in English or Spanish and the mode of completion (by mail or telephone survey).

3.6 Imputing Most Important Reason for Leaving

As noted in a preceding section, the responses to the question asking sample members for their most important reason for leaving their health plan was coded by project staff using 68 unique codes. Some of these codes corresponded to the 33 preprinted reasons in the survey while others provided additional details not addressed in the questionnaire. These codes were assigned to reasons "groupings," comprising a series of related reasons for leaving. There are two main reasons groupings (Problems with Care and Services, and Concerns about Costs), and five subgroupings used in consumer reporting and eight subgroupings used in health plan reporting. The analysis that led to the reasons groupings used on this survey is described in a separate report that was submitted to CMS in July 2001 (Booske and Rudolph, 2001) and in the *2000 Medicare CAHPS Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* submitted to CMS in November 2002 (Harris-Kojetin et al., 2002). Additional details on the reason groupings are provided in the next section, ***Section 3.7***.

[9] This flag applied only to consumer/public reporting, not to health plan reporting.

If the most important reason for leaving the health plan was left blank (missing), the project team imputed a response wherever possible. The following rules were used to impute the most important reason:

- If the respondent marked "yes" to only one preprinted reason for leaving question, then that response was assigned as the most important reason response.

- If "yes" was marked for more than one preprinted reason question, then reasons groupings were examined for imputations. If the two preprinted reasons marked "yes" were in the same main reasons or reasons subgroup, then the most important reason was imputed to be that subgroup.

- If "yes" was marked for two or more preprinted reasons, and each of these fell into different reasons groupings, then the most important reason was left missing.

In the 2003 Reasons Survey, 3,356 (12.5%) of the sample members who returned a completed questionnaire did not record a most important reason for leaving the plan in Question 41. Of those cases, the MIR was imputed for 1,184 cases (4.4%) of the total respondent sample.

3.7 Mapping Reasons to Reasons Grouping

One of the primary purposes of conducting the Reasons Survey is to report reasons to consumers, via the Medicare Web site and other media, to supplement information on the rates at which people voluntarily disenroll from health plans. Although the Reasons Survey collects data about 33 specific reasons for leaving and the one most important reason for leaving, CMS reports most important reason and other reasons for leaving to beneficiaries, the public, and to health plans by two major categories of "most important reasons" cited by people who leave Medicare plans. The CAHPS Disenrollee Development and Testing team tested these two main categories during the development of draft report templates for inclusion of disenrollment rates and reasons on Medicare's Web site, as well as additional testing that was conducted as part of this project. The two categories were given the following labels:

- Members left because of health care or services
- Members left because of costs and benefits

CMS reports each plan's disenrollment rate as a total rate (the percentage of enrollees choosing to leave a plan during the past year) and then broken out according to what percentage of enrollees left for reasons in each of these two main categories. More detailed information about testing on reporting disenrollment rates and reasons to Medicare beneficiaries is provided in reports submitted to AHRQ as part of the CAHPS Disenrollee Development and Testing Project (Harris-Kojetin, Jael, and Hampton, 1999; Harris-Kojetin, Jael, and Nemo, 1999; Harris-Kojetin et al., 1999). Some additional testing of reporting disenrollment rates and reasons was conducted as part of the national implementation. Results from testing conducted as part of this project were described in a report submitted to CMS in January 2000 (Harris-Kojetin, Miller, and Nemo, 2000).

In addition, CMS wanted to allow consumers and health plans interested in more information about either of these categories to be able to "drill-down" to see more detailed subgroupings of reasons. As a result of a series of factor and variable cluster analyses, we developed eight reason groupings based on the data from the 2000 Reasons Survey: five groupings that address problems with care or service and three groupings that address concerns about plan costs. These eight groupings were used for reporting to plans and for subgroup analysis. For the "drill-down" option available to consumers, three of the five care and service subgroupings (Problems getting care, Problems getting particular needs met, and Other problems with care or service) were combined into one group and two of the three cost groupings (Premiums or copayments too high and Copayments increased and/or another plan offered better coverage) were combined into one group for a total of five consumer subgroupings. ***Exhibit 3-1*** presents the assignment of reasons survey items and labels to the reason groupings. More information about reasons groupings and the methodology used to derive those groupings is provided in the 2000 Reasons Survey final analysis report entitled *2000 Medicare CAHPS Disenrollment Reasons Survey: Findings from an Analysis of Key Beneficiary Subgroups* that was submitted to CMS in November 2002 (Harris-Kojetin et al., 2002).

Once the most important reasons were imputed, the assigned code for the most important reason and other reason for leaving the plan were rolled up into main categories that corresponded to the level of detail collected on the 33 preprinted reasons in the survey. At this point, most important reasons and preprinted reasons groupings were created based on the same assignments of the reasons groupings. The most important reason for leaving was mapped to one of the two main reasons groupings, and to the five and eight subgroupings. All reasons that the respondent had marked in the preprinted reasons for leaving were also mapped to the main groupings and subgroupings. It should be noted that a beneficiary could have only one most important reasons grouping but could have multiple preprinted (or "All") reasons groupings. Additionally, although "other reasons" were used to impute the most important reason if it was missing, they were not used in creating the reasons groupings for the annual health plan reports.

Exhibit 3-1
Assignment of Reasons for Leaving a Plan to Groupings of Reasons

Reasons Grouping	Reasons for Leaving a Plan
Problems with Care or Service	
Problems with information from the plan	Given incorrect or incomplete information at the time you joined the plan
	After joining the plan, it wasn't what you expected
	Information from the plan was hard to get or not very helpful
	Plan's customer service staff were not helpful
	Insecurity about future of plan or about continued coverage
Problems getting particular doctors	Plan did not include doctors or other providers you wanted to see
	Doctor or other provider you wanted to see retired or left the plan
	Doctor or other provider you wanted to see was not accepting new patients
	Could not see the doctor or other provider you wanted to see on every visit
Problems getting care	Could not get appointment for regular or routine health care as soon as wanted
	Had to wait too long in waiting room to see the health care provider you went to see
	Health care providers did not explain things in a way you could understand
	Had problems with the plan doctors or other health care providers
	Had problems or delays getting the plan to approve referrals to specialists
	Had problems getting the care you needed when you needed it
Problems getting particular needs met	Plan refused to pay for emergency or other urgent care
	Could not get admitted to a hospital when you needed to
	Had to leave the hospital before you or your doctor thought you should
	Could not get special medical equipment when you needed it
	Could not get home health care when you needed it
	Plan would not pay for some of the care you needed
Other problems with care or service	It was too far to where you had to go for regular or routine health care
	Wanted to be sure you could get the health care you need while you are out of town
	Health provider or someone from the plan said you could get better care elsewhere
	You or another family member, or friend had a bad experience with that plan
Concerns about Costs and Benefits	
Premiums or copayments too high	Could not pay the monthly premium
	Another plan would cost you less
	Plan started charging a monthly premium or increased your monthly premium
Copayments increased and/or another plan offered better coverage	Another plan offered better benefits or coverage for some types of care or services
	Plan increased the copayment for office visits to your doctor and for other services
	Plan increased the copayment that you paid for prescription medicines
	No longer needed coverage under the plan
Problems getting or paying for prescription medicines	Maximum dollar amount the plan allowed for your prescription medicine was too low
	Plan required you to get a generic medicine when you wanted a brand name medicine
	Plan would not pay for a medication that your doctor had prescribed

SECTION 4
CONSUMER, HEALTH PLAN, AND QUALITY IMPROVEMENT ORGANIZATION REPORTING

4.1 Overview

As part of this project, the team compiled and submitted to CMS comparative plan information that CMS later posted on the Medicare Web site. In addition, we compiled and reported—via interim and annual Medicare CAHPS Disenrollment Reasons Survey Health Plan Reports—the results of the survey to the health plans for quality improvement efforts. We also prepared a report for each of the ten CMS Regional Offices, which were submitted to CMS for posting on the HPMS. Annual voluntary disenrollment rates and information about the reasons that Medicare beneficiaries leave their former plans from the 2003 Reasons Survey were posted on the Medicare Web site in early 2005. The results of the 2003 Reasons Survey were prepared and reported to each health plan that participated in the 2003 survey. First, an interim report was sent to the plans in March 2004 based on the first two quarters of data; then an annual health plan report was sent to sample plans in December 2004. This section describes the information that was reported to consumers and health plans, as well as the content of these reports.

4.2 Disenrollment Rates

One of the first steps in preparing for reporting 2003 Reasons Survey results to consumers and to health plans was to calculate raw and adjusted disenrollment rates. CMS calculated an annual voluntary disenrollment rate for each health plan. This rate excludes disenrollment due to death, loss of eligibility, managed care organization (MCO) administrative actions (the effect of contract terminations and contract service area reductions), and beneficiary changes of residence out of a service area. However, CMS does not capture changes in employer coverage in its administrative systems.

As was done with the 2000 through 2002 Reasons Survey, project staff adjusted the 2003 disenrollment rates based on the number of sample members in the 2003 Reasons Survey who reported that they left the plan because their employer no longer sponsored the plan. In addition, RTI adjusted the 2003 disenrollment rates based on the number of sample members who left their plan to join TRICARE for Life. Therefore, RTI project statisticians calculated an "adjusted" disenrollment rate based on the number of sample members in the 2003 survey who reported that they left because their employer stopped offering the plan or because they joined TRICARE. Both the raw (unadjusted) disenrollment rate and the adjusted disenrollment rate were calculated using the number of cumulative annual enrollments and disenrollments in 2003 for each health plan, as provided by CMS. The raw disenrollment rate was computed by dividing the total number of annual enrollees into the total number of annual disenrollments. To create an adjusted disenrollment rate, the raw disenrollment rate was adjusted downward based on the proportion of respondents who reported that they left the plan because their employer no longer offered the plan.

4.3 Interim Report to the Health Plans

We prepared and distributed to each health plan a 2003 Medicare CAHPS Disenrollment Reasons Survey Interim Health Plan Report in March 2004. The data file used in creating this report included data from all eligible cases in Quarters 1 and 2 of the 2002 Reasons Survey that reported at least one reason for leaving the plan (i.e., answered "yes" to one of the preprinted reasons and/or indicated an "other" or "most important" reason for leaving). The Interim Report, which was prepared specifically for each plan, contained a section describing the background and purpose of the survey and sections on the Reasons Survey design and methods. For each individual health plan interim report, we included information about the number of disenrollees sampled for that plan, and the response rate for the first two quarters of the 2002 Reasons Survey. In addition, for each plan, we calculated and included in that plan's interim report the five most frequently cited reasons for leaving that plan, as well as the five most frequently cited most important reasons for leaving the plan. Each health plan report also contained a frequency of responses to each question (unweighted percentages of the survey responses). The report included a copy of the 2003 Reasons Survey questionnaire.

4.4 Annual Report to Health Plans

In December 2004, we prepared and distributed an annual 2003 CAHPS Medicare Disenrollment Reasons Survey Health Plan report to most of the health plans that were included in the 2003 Reasons Survey. At CMS's request, the report was designed to mirror the format of the Medicare CAHPS Managed Care Enrollee Annual Health Plan Report—specifically, the intent was that the annual Reasons Survey Health Plan report should have the "same look and feel" as the Medicare CAHPS Managed Care Enrollee health plan report. Full health plan reports, which included comparative information for all plans within a given state, were provided to all plans with at least 30 respondents in the 2003 Reasons Survey. An Abridged Health Plan Report was prepared and sent to all plans with 10 to 29 respondents. The abridged report did not contain comparative information on other health plans. Plans with fewer than 10 respondents received only a letter.

Data Calculated for Health Plan Reporting—The data file used in creating the 2003 Annual Health Plan report included all cases in Quarters 1-4 of the 2003 Reasons Survey that reported at *least one reason* for leaving the plan (i.e., answered "yes" to one of the preprinted reasons and/or indicated an "other" or "most important" reason for leaving). Cases that were excluded from health plan reporting included responses from sample members who reported that they left their plan because their employer no longer offered the plan or because they left to join TRICARE. Responses from sample members who disenrolled from plans that did not renew their M+C contract with CMS for 2004 or 2005 and plans under new ownership were excluded as well. Data from respondents who disenrolled from contracts that consolidated with other contracts held by the same organization were combined and analyzed with respondent data from the surviving contract; the results from these plans were included in the health plan report prepared for the surviving contract.

The 2003 Reasons Survey Annual Health Plan Report contained information about the sample design and survey methods, data collection results (overall and for the specific plan), raw and adjusted disenrollment rates, and tables showing the percentage of beneficiaries who left the

plan in each of the two main reasons groupings: Problems with Care or Service and Concerns about Costs. In order to make the survey results more useful to the plans in their quality improvement efforts, the two main reasons groupings were divided into eight reasons subgroupings: five for Problems with Care and Services, and three for Concerns about Costs.

The annual health plan report included the state, regional, and national averages for all plans in a state. State averages were reported only for states with at least three Medicare health plans. For states with fewer than three plans, averages for all plans in the CMS region in which the plan was located were reported. If a plan had a service area in more than one state, the data from that plan were included in the state averages of every state in which the plan operated. In addition, the reasons rates for plans that operated in more than one state were shown in the reports prepared for each state in which it operated. However, only one annual health plan report was prepared for a plan that had a service area in multiple states, and it was based on the CMS assigned "site state." Similarly, regional comparisons were based on the CMS designated "responsible region" for each plan.

All survey results displayed in the tables included in the annual health plan report were based on weighted data. CMS decided that survey results reported to consumers and to the public that are posted on the Medicare Web site will be based on *enrollment weights* rather than *disenrollment weights*. This means that Reasons Survey results posted on the Medicare Web site show the percentage of people *enrolled* in the plan during 2003 who left the plan, whereas the results provided in the annual health plan reports where calculated based on disenrollment weights. Therefore, the reasons rates shown in the annual health plan report show the percentages of disenrollees who left the plan. Two sets of results/data included in the annual health plan report were based on *unweighted* rather than weighted data. These include the top five most frequently cited most important reasons and the top five most frequently cited preprinted reasons for leaving. The response frequencies included in each plan's report for individual survey items were also unweighted.

Percentages for each most important reasons grouping and preprinted reasons grouping were produced using SAS by plan and state/region. For the plan comparison information included in each report, the data analysts compared the scores for a particular health plan with the weighted mean for the other plans in the state or CMS region and tested for statistical significance. A two-sample t-test with a p-value of .05 was performed using SUDAAN. Plans with results that were significantly higher or lower (at a level of $p<.05$) than the mean for other plans in the state or region were denoted with an up or down arrow.

4.5 Reporting Survey Results to Consumers and to the Public

The results of the 2003 Reasons Survey, along with annual disenrollment rates, were posted on the Medicare Web site in early 2005. All rates and reasons reported to consumers and the public are based on enrollment weights; that is, the results displayed on the Web site show the percentage of people who were *enrolled* in the plan who chose to leave for the specific reason, rather than showing the percentage of people who disenrolled for a selected reason. We calculated an enrollment weight for each plan for consumer reporting. This weight is simply scaled by a plan-level multiplicative constant so that the weights sum to the proportion that voluntary disenrollees represent of the total population of enrollees.

The information posted on the Web site includes the percentage of enrollees who chose to leave the plan in each of the two main reasons groupings: Problems about Care and Service, and Concerns about Costs. Consumers can also drill down from each of these two main groupings to see the percentage of enrollees who left the plan because of one of three subgroupings of reasons related to Concerns about Care or Service and to two subgroupings or Concerns about Costs. ***Exhibits 4-1*** and ***4-2*** show how these data are displayed on the Medicare Web site.

Exhibit 4-1
Example of How Data Were Displayed on Medicare Web site:
Disenrollment Rates in <<State>>

Percentage of Plan Members Who Left Their Medicare Managed Care Plan in the Year 2003 and the General Reasons Why

	Most Important Reasons Why Members Chose to Leave		
	Members Left Because of Health Care or Services	Members Left Because of Costs and Benefits	Total Percentage of Members Who Chose to Leave
Average for all Medicare managed care plans in <<state>>	%	%	%
«id» «PlanName»	%	%	%
«id» «PlanName»…	%	%	%

Exhibit 4-2
Example of How Data Were Displayed on Medicare Web site:
Specific Reasons Plan Members Left Their Plan in <<State>>

Percentage of Members Who Chose to Leave Their Medicare Managed Care Plan in 2003 and the Specific Reasons Why

	Members Left Because of Health Care or Services			Members Left Because of Costs and Benefits		
	Getting Doctors You Want	Getting Information from the Plan	Getting Care	Premiums, Copayments, or Coverage	Getting or Paying for Prescription Medicines	Total Percentage of Members Who Chose to Leave
Average for all Medicare managed care plans in <<state>>	%	%	%	%	%	%
«id» «PlanName»	%	%	%	%	%	%
«id» «PlanName»…	%	%	%	%	%	%

CMS suppressed disenrollment rates and information about reasons for disenrollment for all plans with a cumulative annual enrollment of less than 1,000 as well as information about reasons for disenrollment for plans with fewer than 100 respondents. Reasons Survey data posted on the Web site show reasons for leaving in two main reasons groupings—members who left because of Health Care or Services, and members who left because of Costs and Benefits. Each of these two main groupings can be drilled down to the five consumer subgroupings: three subgroupings for Health Care or Services, and two subgroupings for Costs and Benefits. Survey results reported to consumers were based only on the most important reason for leaving the plan.

There are two major differences between the data reported directly to plans in their annual report and the data reported to the public. First, the consumer reports are based only on the most important reason for leaving the plan while the results included in the health plan reports are based on the most important reason *and* preprinted reasons (also referred to as "all reasons") for leaving. Second, the results included in the annual health plan report are based on disenrollment weights rather than enrollment weights.

Data Calculated for Consumer Reporting—For each health plan in a state, we calculated an average adjusted disenrollment rate based on all plans in the state, as well as state averages for the two main reasons groupings and the five subgroupings. For consumer and public reporting, survey results for a plan were shown on the Medicare Web site in more than one state *if* that plan had a service area in more than one state. The average state disenrollment rate was calculated using all disenrollees and enrollees over the course of the year for those plans. The state means were calculated as weighted means, or averages, using the responses from all plans within the state. These averages represented the overall average percentage from all plans within the state. After computing the percentage for each most important reasons group by plan and state, the percentage was multiplied by the state-level adjusted disenrollment rate.

To ensure that the sum of the reasons percentages for the two categories and the more detailed five subgroupings always summed to the percentage of disenrollment rates, a two-step method was implemented. If the percentage equaled the adjusted voluntary disenrollment rates, then the percentage was rounded to zero decimal places. If the percentage did not equal the adjusted voluntary disenrollment rates, the percentage was displayed with three decimal places and then manually rounded to ensure that the percentages reported for each subgrouping summed to the appropriate percentage for the two major categories and, in turn, that the percentages for the two major categories summed to the overall disenrollment rate reported for each plan.

Public Report Preview—Prior to posting the results from the 2003 Reasons Survey on the Medicare Web site in early 2005, we prepared and sent a "public report" preview to each Medicare health plan in December 2004. This report contained the same information to be posted on the Medicare Web site. The purpose of sending this report to health plans was to give them an opportunity to preview and comment on the information about their plan before the information was posted on the Medicare Web site.

4.6 Reporting to CMS Regional Offices

In May 2005, we prepared Annual Regional Office (RO) Reports for the ten CMS regional offices, marking the first time that we prepared and distributed this report. The report mirrored

the Annual Health Plan Report distributed to health plans and was designed to help staff in CMS's regional offices understand the experiences of beneficiaries who voluntarily left MA plans in their region. The report was designed after obtaining feedback from staff at nine out of the ten ROs. The results of this feedback were summarized in a report entitled *Feedback from CMS Regional Offices on Disenrollment Reasons Reporting* (Frees and Booske, 2005) submitted to CMS in January 2005. The reports included the same information contained in each plan's Annual Health Plan Report; however, the Regional Office Reports displayed these results for every state in the region. The reports were delivered to CMS in May of 2005 for eventual posting on the HPMS.

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APPENDIX A

2003 MEDICARE CAHPS® DISENROLLMENT REASONS SURVEY QUESTIONNAIRE

OMB No. *0938-0779*

2003 Medicare Satisfaction Survey-DR

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CAHPS®
Consumer Assessment
of Health Plans

Version A

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0779. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

Instructions for Completing This Questionnaire

This questionnaire asks about you and your experiences in a Medicare health plan. Answer each question thinking about yourself. Please take the time to complete the questionnaire because your answers are very important to us.

- Please use a BLACK ink pen to mark your answers.
- Be sure to read all the answer choices before marking your answer.
- Answer all the questions by putting an "X" in the box to the left of your answer, like this:

  ☐ Yes
  ☒ No ➔ **Go to Question 3**

- You will sometimes be instructed to skip one or more questions, depending on how you answered an earlier question. When this happens, you will see an arrow with a note that tells you what question to answer next, as shown in the example above.

  If the answer you marked is not followed by an arrow with a note telling you where to go next, then continue with the next question, as shown below.

EXAMPLE

1. **Do you wear a hearing aid now?**
   ☒ Yes
   ☐ No ➔ **Go to Question 3**

2. **How long have you been wearing a hearing aid?**
   ☐ Less than 1 year
   ☒ 1 to 3 years
   ☐ More than 3 years
   ☐ I don't wear a hearing aid

3. **In the last 6 months, did you have any headaches?**
   ☐ Yes
   ☒ No

IMPORTANT:
PLEASE READ BEFORE
BEGINNING THE QUESTIONNAIRE

Our records show that you were a member of [HEALTH PLAN NAME] and that you left that plan for some period of time during the last 6 months.

If this is correct, please complete this questionnaire about the reasons why you left [HEALTH PLAN NAME].

If you did not leave [HEALTH PLAN NAME], or if you were never enrolled in that plan, please call us toll-free at 1-877-834-7063 and let us know.

REASONS YOU LEFT
[HEALTH PLAN NAME]

The following questions ask about reasons you may have had for leaving [HEALTH PLAN NAME].

Just as it is important for us to learn why you left [HEALTH PLAN NAME], it is also important for us to know what reasons did not affect your decision to leave that plan.

Therefore, please mark an answer for every question below unless the instruction beside the answer that you mark tells you to stop and return the questionnaire, or to skip one or more questions.

1. **Did you leave because you moved outside the area where [HEALTH PLAN NAME] was available?**

   ☐ Yes ➔ **STOP. Do not answer the rest of these questions. Please put your questionnaire in the postage-paid envelope and mail it back to us. Thank you.**

   ☐ No

2. **Did you leave [HEALTH PLAN NAME] because the plan left the area or you heard that the plan was going to stop serving people with Medicare in your area?**

   ☐ Yes

   ☐ No

3. **Did you leave [HEALTH PLAN NAME] because you found out that someone had signed you up for the plan without your knowledge (for example, a relative, salesperson, or someone else)?**

   ☐ Yes

   ☐ No

4. **Did you leave [HEALTH PLAN NAME] because of a paperwork or clerical error (for example, you were accidentally taken off the plan)?**

   ☐ Yes

   ☐ No

5. **Some people leave their Medicare health plan because their former employer no longer offers the plan. Did you leave [HEALTH PLAN NAME] because <u>your former employer or your spouse's former employer no longer offered</u> [HEALTH PLAN NAME] to you?**

- ☐ Yes
- ☐ No
- ☐ Neither I nor my spouse were enrolled in this plan through a former employer.

DOCTORS AND OTHER HEALTH CARE PROVIDERS

A <u>doctor or other health care provider</u> can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

6. **Did you leave [HEALTH PLAN NAME] because <u>the plan did not include the doctors</u> or other health care providers you wanted to see?**

- ☐ Yes
- ☐ No

7. **Did you leave [HEALTH PLAN NAME] because the doctor you wanted to see <u>retired or left the plan</u>?**

- ☐ Yes
- ☐ No

8. **Did you leave [HEALTH PLAN NAME] because the plan doctor or other health care provider you wanted to see was <u>not accepting new patients</u>?**

- ☐ Yes
- ☐ No

9. **Did you leave [HEALTH PLAN NAME] because you could not see the plan doctor or other health care provider you wanted to see on <u>every</u> visit?**

- ☐ Yes
- ☐ No

10. **Did you leave [HEALTH PLAN NAME] because the plan doctors or other health care providers did not explain things in a way you could understand?**

- ☐ Yes
- ☐ No

11. **Did you leave [HEALTH PLAN NAME] because you had problems with the plan doctors or other health care providers?**

- ☐ Yes
- ☐ No

12. **Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.**

    Did you leave [HEALTH PLAN NAME] because you had problems or delays getting the plan to approve referrals to specialists?

- ☐ Yes
- ☐ No

ACCESS TO CARE

13. **Did you leave [HEALTH PLAN NAME] because you had problems getting the care you needed when you needed it?**

- ☐ Yes
- ☐ No

14. **Did you leave [HEALTH PLAN NAME] because the plan refused to pay for emergency or other urgent care?**

- ☐ Yes
- ☐ No

15. **Did you leave [HEALTH PLAN NAME] because you could not get admitted to a hospital when you needed to?**

- ☐ Yes
- ☐ No

16. **Did you leave [HEALTH PLAN NAME] because you had to leave the hospital before you or your doctor thought you should?**

- ☐ Yes
- ☐ No

17. **Did you leave [HEALTH PLAN NAME] because you could not get special medical equipment when you needed it?**

- ☐ Yes
- ☐ No

18. **Did you leave [HEALTH PLAN NAME] because you could not get home health care when you needed it?**

- ☐ Yes
- ☐ No

19. **Did you leave [HEALTH PLAN NAME] because you had no transportation or it was too far to the clinic or doctor's office where you had to go for regular or routine health care?**

- ☐ Yes
- ☐ No

20. **Did you leave [HEALTH PLAN NAME] because you could not get an appointment for health care as soon as you wanted?**

- ☐ Yes
- ☐ No

21. **Did you leave [HEALTH PLAN NAME] because you had to wait too long past your appointment time to see the health care provider you went to see?**

- ☐ Yes
- ☐ No

22. **Did you leave [HEALTH PLAN NAME] because you wanted to be sure you could get the health care you need while you are out of town or traveling away from home?**

- ☐ Yes
- ☐ No

INFORMATION ABOUT THE PLAN

23. Did you leave [HEALTH PLAN NAME] because you thought you were given incorrect or incomplete information at the time you joined the plan?

- ☐ Yes
- ☐ No

24. Did you leave [HEALTH PLAN NAME] because after you joined the plan, it wasn't what you expected?

- ☐ Yes
- ☐ No

25. Did you leave [HEALTH PLAN NAME] because information from the plan about things like benefits, services, doctors, and rules was hard to get or not very helpful?

- ☐ Yes
- ☐ No

PHARMACY BENEFIT

26. Did you leave [HEALTH PLAN NAME] because the maximum dollar amount the plan allowed each year (or quarter) for your prescription medicine was not enough to meet your needs?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

27. Did you leave [HEALTH PLAN NAME] because the plan required you to get a generic medicine when you wanted a brand name medicine?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

28. Did you leave [HEALTH PLAN NAME] because the plan would not pay for a medication that your doctor had prescribed?

- ☐ Yes
- ☐ No
- ☐ The plan that I left did not cover my prescription medicines.

COST AND BENEFITS

29. Did you leave [HEALTH PLAN NAME] because another plan would cost you less?

- ☐ Yes
- ☐ No

30. Did you leave [HEALTH PLAN NAME] because the plan would not pay for some of the care you needed?

- ☐ Yes
- ☐ No

31. Did you leave [HEALTH PLAN NAME] because another plan offered better benefits or coverage for some types of care or services?

- ☐ Yes
- ☐ No

32. A premium is the amount that you pay to receive health care coverage from a health plan. Some health plans charge a premium to people on Medicare who are enrolled in that health plan.

This additional premium that the health plan charges is separate from the premium that people on Medicare pay for Medicare Part B, which is usually deducted from their Social Security Check each month.

Did you leave the plan because [HEALTH PLAN NAME] started charging you a monthly premium, or increased the monthly premium that you pay?

- ☐ Yes
- ☐ No
- ☐ The plan I left did not start charging a premium, nor did it increase my premium.

33. Some people have to leave their Medicare health plan because they cannot afford to pay the premium. Did you leave [HEALTH PLAN NAME] because you could not pay the monthly premium?

- ☐ Yes
- ☐ No

The next two questions ask about co-pays or co-payments, which are the amounts that you pay for certain medical services such as office visits to your doctor, prescription medicines, and other services.

34. Did you leave because [HEALTH PLAN NAME] increased the co-payment that you paid for office visits to your doctor and for other services?

When answering this question, do not include co-payments that you may have paid for prescription medicines.

- ☐ Yes
- ☐ No
- ☐ The plan I left did not increase my co-payment for office visits.

35. Did you leave because [HEALTH PLAN NAME] increased the co-payment that you paid for prescription medicines?

- ☐ Yes
- ☐ No
- ☐ The plan I left did not increase my co-payment for prescription medicines.

OTHER REASONS

36. Did you leave [HEALTH PLAN NAME] because the plan's customer service staff were not helpful or you were dissatisfied with the way they handled your questions or complaints?

- ☐ Yes
- ☐ No

37. Did you leave [HEALTH PLAN NAME] because your doctor or other health care provider or someone from the plan told you that you could get better care elsewhere?

- ☐ Yes
- ☐ No

38. Did you leave [HEALTH PLAN NAME] because you or your spouse, another family member, or a friend had a bad experience with that plan?

☐ Yes

☐ No

39. Besides the reasons already asked about in Questions 2-38, are there any other reasons you left [HEALTH PLAN NAME]?

☐ Yes

☐ No ➔ **If no, go to Question 41 below**

40. On the lines below, please describe your other reasons for leaving [HEALTH PLAN NAME]. *(Please print.)*

_____

_____

_____

41. What was the one most important reason you left [HEALTH PLAN NAME]? *(Please print.)*

_____

_____

_____

YOUR EXPERIENCE WITH [HEALTH PLAN NAME]

The next set of questions is about your experience with [HEALTH PLAN NAME].

42. People who have a prescription medicine drug discount card get a discount on some prescription medicines when they show the card at a participating pharmacy. A prescription drug discount card is not insurance.

When you were a member of [HEALTH PLAN NAME], did you have a prescription medicine drug discount card that allowed you to buy prescription medicines at a discount?

- ☐ Yes
- ☐ No

43. At the time that you left [HEALTH PLAN NAME], did this plan cover some or all of the costs of your prescription medicines?

- ☐ Yes
- ☐ No

44. For about how many months were you a member of [HEALTH PLAN NAME] before you left?

- ☐ 1 month or less
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months or more

Some of the following questions ask about the last 6 months you were in [HEALTH PLAN NAME]. If you were in this plan for less than 6 months, answer the questions thinking about the number of months that you were a member of that plan.

45. In the 6 months before you left [HEALTH PLAN NAME] (not counting times you went to an emergency room), how many times did you go to a doctor's office or clinic to get care for yourself?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a physician assistant, or a nurse.

46. Did you get a new personal doctor or nurse when you were a member of [HEALTH PLAN NAME]?

- ☐ Yes
- ☐ No

47. Think about all the health care you got from <u>all doctors and other health providers</u> in the 6 months before you left [HEALTH PLAN NAME].

Using <u>any number from 0 to 10</u> where 0 is the worst health care possible, and 10 is the best health care possible, what number would you use to rate all your health care?

- ☐ 0 ➔ Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 ➔ Best health care possible

48. Think about all your experience with [HEALTH PLAN NAME].

Using <u>any number from 0 to 10</u> where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate [HEALTH PLAN NAME]?

- ☐ 0 ➔ Worst health plan possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 ➔ Best health plan possible

APPEALS AND COMPLAINTS

You have the right to file an appeal if a doctor or if [HEALTH PLAN NAME] made a formal decision not to provide or pay for health care services, or to stop providing health care services.

49. When you were a member of [HEALTH PLAN NAME], was there ever a time when you strongly believed that you needed and should have received health care or services that <u>your doctor</u> decided not to give you?

- ☐ Yes
- ☐ No
- ☐ Don't know

50. Before today, did you know that you can ask [HEALTH PLAN NAME] to reconsider your doctor's decision not to provide health care or services?

- ☐ Yes
- ☐ No

51. When you were a member of [HEALTH PLAN NAME], did <u>your doctor's office</u> provide you with any information about what to do if a doctor did not give you a service that you believed you needed?

- ☐ Yes
- ☐ No
- ☐ Don't know

52. When you were a member of [HEALTH PLAN NAME], was there ever a time when you strongly believed you needed care or services that <u>[HEALTH PLAN NAME]</u> decided not to give to you?

- ☐ Yes
- ☐ No ➔ **If no, go to Question 56 on the next page**

53. Did you ever speak to someone at [HEALTH PLAN NAME], either in person or over the telephone, to ask them to reconsider a decision not to provide or pay for health care or services?

- ☐ Yes
- ☐ No ➔ **If no, go to Question 56 in the next column**
- ☐ Don't know ➔ **If don't know, go to Question 56 in the next column**

54. When you called or spoke to [HEALTH PLAN NAME] in person about your complaint, did they…

Please mark one or more.

- ☐ Tell you that your complaint could be filed as an appeal
- ☐ Send you forms that you need to complete to change your complaint into an appeal or offer to send you forms that you need for an appeal
- ☐ Suggest how to resolve your complaint
- ☐ Listen to your complaint but did not help resolve it
- ☐ Discourage you from taking action about your complaint

55. While you were a member of [HEALTH PLAN NAME], did your doctor ever ask someone at [HEALTH PLAN NAME] to reconsider the plan's decision not to provide or pay for health care or services?

- ☐ Yes
- ☐ No
- ☐ Don't know

56. Before today, did you know that you can file an official appeal in writing to your plan?

- ☐ Yes
- ☐ No ➔ **If no, go to Question 58 on the next page**

57. Did you ever submit an official appeal in writing to [HEALTH PLAN NAME] asking them to reconsider a decision not to provide or pay for health care or services?

- ☐ Yes
- ☐ No
- ☐ Don't know

58. The Medicare program is trying to learn more about the health care or services that Medicare health plans provide to beneficiaries.

May we contact you again about the health care services provided by [HEALTH PLAN NAME]?

- ☐ Yes
- ☐ No

ABOUT YOU

The next set of questions asks for your views about your health, about how you feel and how well you are able to do your usual activities.

59. In general, how would you rate <u>your overall health</u> now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

60. Compared to one year ago, how would you rate your health in general now?

- ☐ Much better now than one year ago
- ☐ Somewhat better now than one year ago
- ☐ About the same as one year ago
- ☐ Somewhat worse now than one year ago
- ☐ Much worse now than one year ago

61. In general, how would you rate your overall <u>mental</u> health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

The next two questions are about activities you might do during a typical day.

62. Does your health now limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

63. Does your health now limit you in climbing several flights of stairs? If so, how much?

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No, not limited at all

The next two questions ask about your physical health and your daily activities in the past 4 weeks.

64. During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?

- ☐ Yes
- ☐ No

65. During the past 4 weeks, were you limited in the kind of work or other activities you did as a result of your physical health?

- ☐ Yes
- ☐ No

The next two questions ask about problems with your work or other regular daily activities as a result of any emotional problems, such as feeling depressed or anxious.

66. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?

- ☐ Yes
- ☐ No

67. During the past 4 weeks, did you do work or other regular activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?

- ☐ Yes
- ☐ No

68. During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

The next three questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

69. How much of the time during the past 4 weeks have you felt calm and peaceful?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

70. How much of the time during the past 4 weeks did you have a lot of energy?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

71. How much of the time during the past 4 weeks have you felt downhearted and blue?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

72. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

73. What is your age now?

- ☐ 44 or younger
- ☐ 45 to 64
- ☐ 65 to 69
- ☐ 70 to 74
- ☐ 75 to 79
- ☐ 80 to 84
- ☐ 85 or older

74. Are you male or female?

- ☐ Male
- ☐ Female

75. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

76. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

77. What is your race? Please mark one or more.

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native

78. Did someone help you complete this questionnaire?

☐ Yes ➔ **If yes, go to Question 79 below**

☐ No ➔ **If no, go to Question 80 in the next column**

79. How did that person help you? Please check all that apply.

☐ Read the questions to me

☐ Wrote down the answers I gave

☐ Answered the questions for me

☐ Translated the questions into my language

☐ Helped in some other way *(Please print.)*

_____

_____

80. We would like to be able to contact you in case we have any questions about any of your answers. Please write your daytime telephone number below.

☐☐☐ ☐☐☐ ☐☐☐☐

THANK YOU.
Please mail your completed questionnaire in the postage-paid envelope.

APPENDIX B

SUMMARY OF PROJECT HOTLINE EXPERIENCE: 2003 MEDICARE CAHPS® DISENROLLMENT REASONS SURVEY

Summary Of Project Hotline Experience
2003 Medicare CAHPS® Disenrollment Reasons Survey

The project's toll-free telephone hotline provides an important means of collecting information about sample members. The hotline number can be found on all of the mailings that sample members receive. Sample members are encouraged to call if they have any questions about the survey or would like to find out how to complete the survey over the phone. ***Table B-1*** shows the number of calls received to the hotline for each quarter of the 2001 through 2003 Reasons Surveys.

Table B-1
Calls to the Project Hotline by Quarter

	Number of Callers		
Quarter	**2003 Reasons Survey**	**2002 Reasons Survey**	**2001 Reasons Survey**
Quarter 1	920	861	1,586
Quarter 2	884	717	1,200
Quarter 3	815	922	1,422
Quarter 4	2,897	1,530	2,889
Total Calls	5,516	4,030	7,097
Total Sample Size	59,072	53,241	64,430
Percentage Using Hotline	9.3%	7.6%	11.0%

As was done in the 2002 Reasons Survey, we used a hotline component as part of the same CATI instrument being used for telephone interviews to receive and process calls from sample members. Using a structured CATI for inbound hotline calls ensured consistency in how hotline staff responded to callers and handled calls. Experienced telephone interviewers, who had previously worked on the Medicare CAHPS Disenrollment Survey, were specially trained to handle hotline calls using the CATI. This 4-hour training included mock hotline calls and a discussion of how to handle calls as accurately, efficiently and compassionately as possible.

When someone called the hotline, hotline staff indicated the reason for the call to the hotline according to the nine categories listed in the CATI. These nine categories were:

- Question about the survey, Medicare or the health plan
- Question about the survey requiring project staff follow-up (e.g., the caller may have asked to speak to the Data Collection Manager)
- Request for a telephone interview

- Address Change or update information
- Refusal
- Sample member incapable of participating
- Sample member deceased
- Sample member institutionalized
- Reporting a reason the sample member left the plan

Table B-2 shows the reason for all hotline calls by quarter, and for the entire 2003 survey year. **The largest number of calls (56.6%) came from those respondents wanting to give a reason for leaving their Medicare plan**. This number includes sample members who were calling to explain that they moved out of the plan's service area, were still with the health plan and those who said they were never on the plan. These sample members were coded as ineligible. Sample members who indicated that they left the plan because the plan stopped serving Medicare beneficiaries in their area, they were signed up for the plan without their knowledge, or they were accidentally disenrolled due to a paperwork or clerical error were asked if this was their only reason for leaving. If additional reasons were identified, hotline staff was trained to ask the sample member to do a telephone interview. Many sample members gave reasons for leaving that did not make them ineligible (for example, their doctor left the plan). Hotline staff was trained to encourage the sample member to complete the interview, either by mail or by phone.

Approximately 19% of callers wanted to ask a question about the survey, Medicare, or their health plan that did not require follow-up action by project staff. Hotline TIs were trained to direct questions about Medicare and health plans to the National Medicare hotline. The telephone number for the Medicare hotline is programmed into the hotline CATI as a "help" screen so that it is easily accessible.

Respondents who called in to request a telephone interview composed the third largest group of hotline callers (9.4%). Hotline TIs were also trained to set up appointments for these cases to be called at the sample member's convenience.

Information gathered from talking with sample continues to inform our understanding of the way the questionnaire items are "working."

Table B-3 shows the reasons given for leaving the plan for all hotline calls by quarter, and for the entire 2003 survey year. **A majority of the hotline calls from sample members who called to cite a reason for leaving were from sample members citing a reason that made them ineligible.** The major reasons for ineligibility were that the sample member never left the plan or that they moved out of the area where the plan was offered. The large number of people who stated that they never left the plan could be attributed to a lack of understanding about what it means to disenroll from a plan, to the fact that they may have switched products within a given health plan contract number, or perhaps due to administrative issues within the CMS databases.

Approximately 31% of respondents who called to cite a reason why they left their plan gave a reason which did not make them ineligible and were thus encouraged to either return the questionnaire by mail or do the interview over the telephone.

Table B-2
2003 Reasons Survey Hotline Usage

Call-In Hotline Option	Responses by Quarter									
	Qtr. 1		Qtr. 2		Qtr. 3		Qtr. 4		Total Qtrs. 1-4	
	Freq.	Column %	Freq.	Column %	Freq.	Column %	Freq.	Column %	Freq.	Column %
Question About Survey, Medicare or Health Plan: *No Further Action Needed*	195	20.8%	161	18.1%	137	16.9%	298	19.7%	**791**	**19.1%**
Question About Survey: *Project Staff Follow-Up Needed*	29	3.1%	17	1.9%	15	1.8%	32	2.1%	**93**	**2.2%**
Telephone Interview Request	120	12.8%	106	11.9%	81	10.0%	83	5.5%	**390**	**9.4%**
Address Change or Update	2	0.2%	2	0.2%	5	0.6%	6	0.4%	**15**	**0.4%**
Refusal by SM	44	4.7%	49	5.5%	31	3.8%	42	2.8%	**166**	**4.0%**
SM Incapable of Participating in Interview	8	0.9%	4	0.4%	6	0.7%	5	0.3%	**23**	**0.6%**
Deceased	26	2.8%	16	1.8%	19	2.3%	19	1.3%	**80**	**1.9%**
Institutionalized (Nursing Home, Assisted Living)	35	3.7%	47	5.3%	41	5.0%	24	1.6%	**147**	**3.5%**
Reason Left Plan	456	48.6%	458	51.5%	461	56.8%	974	64.5%	**2349**	**56.6%**
"Unresolved Cases"	24	2.6%	30	3.4%	26	3.2%	28	1.9%	**108**	**2.6%**
Total Number of Calls to Hotline by Qtr	939	100.0%	890	100.0%	812	100.0%	1511	100.0%	**4152**	**100.0%**

Table B-3
2003 Reasons Survey "Reasons Left Plan" Frequencies

Call-In Hotline Option	Responses by Quarter									
	Qtr. 1		Qtr. 2		Qtr. 3		Qtr. 4		Total Qtrs. 1-4	
	Freq.	Column %	Freq.	Column %	Freq.	Column %	Freq.	Column %	Freq.	Column %
Moved Outside the Area where Plan was Available	65	14.3%	74	16.2%	109	23.6%	110	11.3%	**358**	**15.2%**
Plan Left Area or SM Heard Plan was going to Stop Serving People with Medicare in Area	6	1.3%	12	2.6%	7	1.5%	56	5.7%	**81**	**3.4%**
Someone Signed SM up for Plan without SM's Knowledge	9	2.0%	1	0.2%	7	1.5%	11	1.1%	**28**	**1.2%**
Left because of Paperwork or Clerical Error	17	3.7%	11	2.4%	21	4.6%	26	2.7%	**75**	**3.2%**
Never on Plan	44	9.6%	45	9.8%	40	8.7%	41	4.2%	**170**	**7.2%**
Still in Plan, Never Left	234	51.3%	251	54.8%	215	46.6%	213	21.9%	**913**	**38.9%**
Other Reason	81	17.8%	64	14.0%	62	13.4%	517	53.1%	**724**	**30.8%**
Total Number of Calls reporting "Reason Left Plan" by Qtr	456	100.0%	458	100.0%	461	100.0%	974	100.0%	**2349**	**100.0%**

APPENDIX C

MOST IMPORTANT AND OTHER REASONS FOR LEAVING CODE LIST

2003 Medicare CAHPS® Disenrollment Reasons Survey: Most Important and Other Reason for Disenrolling Code List

Considered Involuntary Reasons for Disenrolling

420 Deceased
430 Institutionalized (nursing home, assisted living, retirement home, long-term care facility)
440 Still with plan, never left it
450 Plan was no longer offered (available) to me (Q2)
460 I moved and now live outside the area where the plan was available (Q1)
465 I was enrolled without my knowledge (for example, by a friend, relative or salesperson) (Q3)
475 I was accidentally disenrolled (for example, by a paperwork or clerical error) (Q4)

Misc. voluntary reason

40 Employer stopped offering plan (Q5)
51 Insecurity about future of plan or about my continued coverage

Doctors and Other Health Care Providers

70 The plan did not include the doctors or other health providers I wanted to see (Q6)
71 Plan did not use hospital you wanted to go to
72 Did not like/trust/*get good care from*/want to see available plan doctors or other health providers
75 Dissatisfied with doctor's office staff
80 The doctor I wanted to see retired or left the plan (Q7)
81 Doctor you wanted to see was dropped by plan
90 The plan doctor or other health provider I wanted to see was not accepting new patients (Q8)
100 I could not see the plan doctor or other health provider I wanted to see on every visit (Q9)
110 The plan doctors or other health providers did not explain things in a way I could understand (Q10)
111 Could not understand plan doctors or other health providers (e.g., language barrier)
120 I had problems with the plan doctors or other health care providers (Q11)
130 I had problems or delays getting the plan to approve referrals to specialists (Q12)
131 Plan doctor(s) would not refer you to the specialist you needed to see

Access to Care

140 I had problems getting the care I needed when I needed it (Q13)
141 Took too long for appointments, care, services, approvals, or to be seen in doctor's office
150 The plan refused to pay for emergency or other urgent health care (Q14)

160 I could not get admitted to a hospital when I needed to (Q15)
161 Deductible or co-payment for hospital stay was too expensive
170 I had to leave the hospital before I or my doctor thought I should (Q16)
180 I could not get special medical equipment when I needed it (Q17)
190 I could not get home health care when I needed it (Q18)
200 I had no transportation or it was too far to the clinic or doctor's office where I had to go for regular or routine health care (Q19)
210 I could not get an appointment for regular or routine health care as soon as I wanted (Q20)
220 I had to wait too long past my appointment time to see the health care provider I went to see (Q21)
230 I wanted to be sure I could get the health care I need while I am out of town or traveling away from home (Q22)

Information About the Plan

240 I thought I was given incorrect or incomplete information at the time I joined the plan (Q23)
250 After I joined the plan, it wasn't what I expected (Q24)
260 Information from the plan about things like benefits, services, doctors, and rules, was hard to get or not very helpful (Q25)

Pharmacy Benefit

270 The maximum dollar amount the plan allowed each year (or quarter) for my prescription medicine was not enough to meet my needs (Q26)
271 Cost of medications was or became too high
280 The plan required me to get a generic medicine when I wanted a brand name medicine (Q27)
290 The plan would not pay for a medication that my doctor had prescribed (Q28)
291 Plan eliminated or had no prescription coverage
299 Unspecified dissatisfaction with pharmacy benefits

Cost and Benefits

300 Another plan would cost me less (Q29)
301 Former plan was or became too expensive/Could not afford the monthly premium (Q33)
302 Former plan reduced or changed benefits or coverage
310 The plan would not pay for some of the care I needed (Q30)
320 Another plan offered better benefits or coverage for some types of care or services (Q31)
321 Another plan offered (better or cheaper) *dental* benefits or coverage
322 Another plan offered (better or cheaper) *home health care* benefits or coverage
323 Another plan offered (better or cheaper) *pharmacy* benefits or coverage
324 Another plan offered (better or cheaper) *vision* benefits or coverage
330 The plan started charging me a monthly premium or increased the monthly premium that I pay (Q32)

340 The plan increased the co-payment that I paid for <u>office visits</u> to my doctor <u>and for other services</u> (Q34)

350 The plan increased the co-payment that I paid for <u>prescription medicines</u> (Q35)

Other Reasons

360 The <u>plan's customer service staff were not helpful</u> or I <u>was dissatisfied with the way they handled my questions or complaint</u> (Q36)

361 Didn't like changes plan made or that plan could make changes it wanted to when it wanted to

362 Plan was not concerned about or for patients

363 Plan did not help with administrative matters or correct administrative errors

364 Felt wronged, poorly served, or unfairly treated (by whom not specified)

365 Don't like HMO's

366 Problems with billing from the plan

369 Unspecified dissatisfaction with plan

370 My doctor or other health care provider or someone from the plan <u>told me that I could get better care elsewhere</u> (Q37)

371 Influenced by sales person/literature/presentation or by a friend or relative to change plans

380 I or my spouse, another family member, or a friend <u>had a bad *(medical)* experience</u> with that plan (Q38)

390 No longer needed coverage under the plan

391 Never used the plan

392 Now on Medicaid

393 Have VA benefits

394 Have TRICARE/CHAMPUS military benefits

500 Miscellaneous (Unable to code as a reason for disenrolling)

501 Opinion/just wanted to leave/regret (no reason for disenrolling given), "none"

600 Left because heard about Lock-in

000 Blank, -1, N/A, Don't know, No ➔ gets recoded to Missing

APPENDIX D

CHANGES MADE TO THE 2004 REASONS SURVEY QUESTIONNAIRE

Changes Made to the 2004 Reasons Survey Questionnaire

After every survey implementation, the project team reviews the questionnaire to evaluate whether changes are warranted for the subsequent annual implementation. Sometimes the changes are prompted by changes being made to similar questions on the two other major CAHPS surveys that CMS conducts. Other reasons for making a change are related to how sample members are interpreting the existing questions. Changes made to the 2003 Reasons Survey were prompted by two issues: first, as a result of the cognitive testing activities conducted from November 2003-January 2004 to evaluate the most important reason, we made a series of changes to the formatting and placement of the two open-ended text questions. Second, the MMA CAHPS team and the Disenrollment team together revised the existing series of "Appeals and Complaints" questions and replaced them with a new set.

A summary of changes that we made to the 2003 Reasons Survey questionnaire prior to the 2004 survey implementation is provided below.

- We switched the order of the most important and other reason questions. This was done to try to reduce the number of respondents who wrote their most important reason in the "other" reason question, which used to come first and then who left the next question blank. In addition, we made some formatting changes to try to emphasize the most important reason, including putting a box around the question.

- We dropped Question 42:

  42. When you were a member of PLAN, did you have a prescription medicine drug discount card that allowed you to buy prescription medicines at a discount?

  ☐ Yes
  ☐ No

- We worked with the Enrollee Survey contractor to revise the Appeals and Complaints series of questions, replacing the existing set with the following new set:

  You have the right to file an appeal if a doctor or if [HEALTH PLAN NAME] decided not to provide or pay for health care services or stopped providing health care services.

  48. When you were a member of [HEALTH PLAN NAME], was there ever a time when you believed that you needed and should have received health care or services that <u>your doctor</u> decided not to give you?

  ☐ Yes
  ☐ No
  ☐ Don't know

  49. Before today, did you know that you can ask [HEALTH PLAN NAME] to reconsider your doctor's decision <u>not</u> to provide health care or services?

  ☐ Yes
  ☐ No

50. When you were a member of [HEALTH PLAN NAME], did <u>your doctor's office</u> provide you with any information about what to do if a doctor did not give you the care or service that you believed you need?

- ☐ Yes
- ☐ No
- ☐ Don't know

51. When you were a member of [HEALTH PLAN NAME], was there ever a time when you believed you needed care or services that [HEALTH PLAN NAME] decided not to give you?

- ☐ Yes
- ☐ No ➔ **If no, go to Question 55**

52. Have you ever asked anyone at [HEALTH PLAN NAME] to reconsider a decision not to provide or pay for health care or services?

- ☐ Yes
- ☐ No ➔ **If no, go to Q55**

53. When you spoke to [HEALTH PLAN NAME] about the decision not to provide care or services, did they…

Please mark one or more.

- ☐ Tell you that you can file an appeal
- ☐ Offer to send you forms that you need to file an appeal
- ☐ Suggest how to resolve your complaint
- ☐ Listen to your complaint but did not help resolve it
- ☐ Discourage you from taking action

54. Did your doctor ever ask someone at [HEALTH PLAN NAME] to reconsider its decision not to provide or pay for health care or services?

- ☐ Yes
- ☐ No
- ☐ Don't know

55. Before today, did you know that you could file an appeal in writing to your plan?

- ☐ Yes
- ☐ No ➔ **If no, go to Question 57**

56. Did you ever submit an appeal in writing to [HEALTH PLAN NAME] asking them to reconsider a decision not to provide or pay for care or services?

- ☐ Yes
- ☐ No
- ☐ Don't know

57. The Medicare program is trying to learn more about your Medicare experience.

May we contact you again about your experiences?

- ☐ Yes
- ☐ No